AN EMPOWERMENT ORIENTED FRAMEWORK FOR PRACTICE WITH HOMELESS MENTALLY ILL CLIENTS

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Introduction

The service needs of the homeless mentally ill population are a growing concern of policy makers, program planners, and social work practitioners. In many localities, funds have been made available to develop service programs targeted at this population. The development of services has proceeded largely on a trial and error basis, however, due to the paucity of research concerning the effectiveness of various program models, the lack of available information about the experiences of participants in service programs, and the embryonic stage of practice model development.

The particular challenges faced by social workers attempting to serve homeless mentally ill clients suggest the need for research in this emerging field of practice. The paucity of knowledge regarding the histories of homeless mentally ill people and the circumstances under which they became homeless further suggests that research be focused on the homeless clients served by social programs, as well as on service provision.

The small but growing body of literature on practice with homeless mentally ill clients is rich in experiential data and anecdotal information (Lee, 1986; Berman-Rossi and Cohen, 1988; Glasser and Suroviak, 1988; Martin and Neyowith, 1988). There is consensus in this literature that practice with this vulnerable client population should be "empowerment oriented." Further conceptualization of this practice approach would greatly aid the development of practice models to guide social workers in providing services.

This paper will discuss the findings of a doctoral research study (Cohen, 1988) which examined the relationship between clients and staff of a residentially based service program for homeless mentally ill women during the first two years of program development. The practice implications of this study will be explored and an empowerment oriented framework for practice with homeless mentally ill clients will be proposed.

The Study

Research Context

The setting of the study was an SRO hotel in the Times Square neighborhood of New York City. The hotel is operated by a small community agency and functions as a transitional residence for homeless mentally ill women. The host agency staffs the hotel around the clock. In addition, an agency affiliated with a graduate school of social work operates a Community Support Systems (CSS) program in the hotel five days a week, providing comprehensive case management services and a group activities program. It is staffed by a CSS team consisting of a social work supervisor, two case managers, a psychiatric consultant, and two graduate social work interns.

The primary focus of the study is the development of the CSS program and its clients. The hotel had been in operation for a year prior to the implementation of the CSS program. As involvement in the CSS program was voluntary, only a portion of the hotel's thirty-six residents were clients of the program at any one time.

Research Questions

The major objective of this exploratory study was to analyze the interaction between the program and its clients and trace changes in both during a two year period, in order to assess their influence on each other. The following research questions guided the analysis:

1. What was the nature of the interaction between the service program and its clients during the first two years of the program's development?

2. How did this interaction influence the evolution of the program and its clients?

The Random House Dictionary of the English Language defines "interaction" as "reciprocal action or influence" (Stein, 1966, p.739). The first research question focuses on an exploration of the reciprocal behavior between these two systems over time. The second research question focuses on an examination of the effects of this reciprocal behavior on each of the systems, as reflected by modifications in the program and in client behavior.

Methodology

The major variables of interest in this study were the CSS program at the hotel and the clients who were served by the program during its first two years of operation (1983-1985). In order to investigate the research questions posed above, a research strategy using a variety of qualitative methods and multiple sources of data was employed.

The experiences of staff and clients were traced through data obtained from in-depth interviews with a variety of informants: staff and student members of the CSS team, staff of the host agency which operated the hotel, consultants from the New York City Department of Mental Health which funded the CSS program and monitored its progress, and clients of the CSS program.

Interviews were semi-structured, consisting of a series of open ended questions. A topical interview outline was used to guide and focus the interviews. Respondents were questioned about: their early impressions of the hotel and the program; changes in the hotel environment, the clients, and the program over time; their perceptions of the client/worker and client/program relationships; and their assessment of the extent of client influence on the program and program influence on clients.

In addition to interview data, information was obtained through an analysis of program records, client charts, and third party reports (primarily hospital records). Participant observation techniques were employed throughout the two year period studied.

It should be noted that the researcher was also the director of the CSS program studied. As such, complete objectivity in this inquiry cannot be claimed. The close relationship between the researcher and the program was critical, however, to gaining unique access to data that a more impartial observer would have lacked.

Characteristics of the Study Population

Two criteria were used to define the client members of the research population: (1) residency at the hotel prior to the inception of the CSS program and (2) active involvement as clients of the CSS Program during the two year study period. Nineteen clients fit these criteria. Thirteen agreed to participate in the interview process.

A demographic profile of the study population, including the six women who did not participate in the interviews, is presented in Table 1. This table allows for a comparison of the clients who participated in the study with those who did not.

Table 1

Demographic Profile of the Research Population

Demographic Characteristics			N=19
Age	Participants	Non-Participants	Total
31-40 yrs	5	0	5
41-50 yrs	2	1	3
51-60 yrs	5	1	6
61-70 yrs	1	4	5
Race	Participants	Non-Participants	Total
Caucasian	11	4	15
Black	2	2	4
Other	0	0	0
Religion	Participants	Non-Participants	Total
Protestant	7	2	9
Catholic	3	3	6
Jewish	3	1	4
Birth Place	Participants	Non-Participants	Total
New York City	5	5	10
New England	2	0	2
South	3	1	4
Midwest	2	0	2
Europe	2	0	2
Family of Origin	Participants	Non-Participants	Total
Business	2	0	2
Professional	1	0	1
Farm	1	1	2
Blue Collar	8	4	12
Unemployed	1	0	1

Educational Attainment	Participants	Non-Participants	Total
Some High School	2	2	4
High School Degree	5	4	9
Some College	5	0	5
College Degree	0	0	0
Some Grad School	1	0	1
Psychiatric History	**Participants**	**Non-Participants**	**Total**
Known History of Hospitalization	6	3	9
No Known History	7	3	10

The ages of the research population range from thirty-two to seventy; more than half of the population is over the age of fifty. The study participants tended to be younger than the non-participants and none of the non-participants were under forty-one years of age.

The research population is overwhelmingly Caucasian with a small number of Blacks. No other minority groups are represented. The participant group had an even larger proportion of Caucasians than did the non-participant group.

Not surprisingly, half the research population is comprised of native New Yorkers. The remaining subjects are from the South, New England, the Midwest, and Europe. The geographic distribution of non-participants is similar to that of the research population as a whole.

Almost two-thirds of the women in the research population come from blue collar, working class families. The participant group reflects a somewhat broader spectrum of social class backgrounds than the non-participant group; all of the women in the research population who were from business, professional, and unemployed family backgrounds participated in the study. In view of the prevailing stereotypes about the homeless population, it should be noted that few members of the research population have family backgrounds characterized by unemployment and poverty.

Interestingly, the vast majority of members of the research population are high school graduates, many of whom also attended college. One member completed college and attended

graduate school. The study participants generally had a higher level of educational attainment than the non-participants, almost half of the participant group attended college while none of the non-participant group did.

Despite the fact that the entire research population had been diagnosed as mentally ill, fewer than half admitted to histories of psychiatric hospitalization (the actual number having been hospitalized is likely to be somewhat higher). There was little difference between the participant and non-participant groups with regard to known histories of hospitalization.

In summary, the research population is predominantly Caucasian, over the age of fifty, high school educated, and from working class families. More than half were born in New York City, less than half have documentable histories of psychiatric hospitalization. The six members of the population who did not participate in the study differ from the participants primarily with regard to age, race, and education. The non-participant group includes a higher proportion of women over the age of fifty, women who are Black, and woman who did not complete high school.

As summarized in Table 2, the histories of all nineteen women were characterized by experiences of loss.

Table 2

Measures of Loss In Nineteen Homeless Women

Categories of Loss	N=19	Percentage
Parental death during childhood	8	42.1
Parental abandonment during childhood	4	21.1
Parental divorce during childhood	4	21.1
Involuntary loss of contact with family	4	21.1
Widowhood before age 30	3	27.3*
Divorce and permanent separation	8	72.7*
Lost custody of children, no further contact	4	21.1
Children left home, no further contact	3	15.8
Total number sustaining one or more major losses	19	100

*Percentage of those who married

Whether the result of the death or abandonment of a parent, early widowhood, marital break-up, or loss of custody of children, every woman in the study population sustained at least one major loss prior to being designated mentally ill or becoming homeless.

All of these nineteen women lived a marginal existence during a considerable portion of their lives. For the majority, marginality came early. Three dropped out of high school. Ten permanently left the workforce prior to the age of thirty. Six others were employed only sporadically. Although most of the women were from working class or middle class families, all were downwardly mobile with respect to their parents and siblings.

For at least half the women, loss was followed by dissolution of work and family ties, dissolution of social ties by contact with the mental health system and the label of mental illness, and mental illness by the experience of homelessness.

The immediate cause of homelessness for most of the women was eviction combined with the lack of affordable housing in New York City. Of the thirteen women who were evicted into homelessness: four were evicted due to the closing of an SRO hotel, eight were evicted due to nonpayment of rent, and one was evicted from the rent controlled apartment in which she had lived for fifty years, because her name was not on the lease. Of the six women who were not evicted: two had left New York City, only to return several years later and find that rents had increased so dramatically that they were unable to secure housing, three became homeless after leaving apartments they had shared with relatives and the fourth was discharged into homelessness following a psychiatric hospitalization. The immediate cause of homelessness for all of the women in the study population was economic; their own poverty combined with the harsh realities of the real estate market.

The marginal lifestyle of these women appears to have played a direct role in the genesis of their homelessness. With sporadic histories of workforce participation, limited marketable skills and the absence of family supports to fall back on, eviction virtually insured homelessness, particularly since the homeless were ineligible for public assistance. Mental illness and hospitalization is likely to have played an indirect role in the creation of homelessness. The limited work force participation of these women is, in part, a function of emotionally instability and a result of years of institutionalization. It also seems likely that the label of mental illness and/or the

inability to account for many years of unemployment may have lead to discrimination in employment. Nonetheless, mental illness was not, per se, the cause of homelessness for any of the women in the study population.

The patterns of these women's lives suggest early experiences of severe loss and a marginal relationship to the workforce prior to any involvement in the mental health system. Limited family ties and poor work histories left the women without familial or financial resources to turn to when faced with eviction at a time when the cost of housing in New York City was at a record high.

Findings

Client Influence on Program Development

Most of the respondents felt that the clients played an influential role in program development. As one of the clients stated in her interview:

> I think that the clients had alot of influence on all of the program's changes...As time went on, the clients became more open with the staff and trusted them more. This influenced what the staff could do. It helped the staff to have more groups and to be be able to work with more people...The women wanted more groups and asked for them. More people came to the staff for help...The clients really made the program grow.

The data suggest that clients played a critical role in shaping the development of the program. However, while client preference (as defined by clients) clearly influenced the program's evolution, client need (as defined by program staff) also exerted a powerful influence. While

the program was consciously client-centered in its approach to practice and programming, client input into program planning was structured and limited by program staff. For example, the staff actively sought direction from clients as to what groups would be offered as part of the group activities program. Clients were informed of the amount of money available in the budget for program activities and asked to decide how these monies should be allocated. Clients were not asked, however, whether they wanted a group activities program in the first place.

The analysis of the data revealed three dimensions of client influence on program development: (1) client's needs

were assessed by the team in planning program services, (2) clients participated in limited programmatic decision making, and (3) clients determined the success or the failure of the program by their willingness to become involved in program services.

Program Influence on Individual Clients

The data suggest that the program had an impact on most of the clients, in such areas as: increased emotional stability, improved functioning ability, enhanced self-esteem, and improved interpersonal relationships. The vast majority of the study population were found to have made significant personal changes in which the program played an instrumental role. One client described the impact the program had on her as follows:

> Last Spring I felt very withdrawn from everyone, I was in very bad shape. I had alot of trouble communicating with people but I've gotten alot better at it. I've worked out alot of my problems and found that there are alot of people here I can talk to who will listen...I still get moody but I don't get out of control like I used to...The CSS program had alot to do with it. The groups and the individual time with the workers helped me alot...I'm treated differently here...I'm treated with respect.

Many of the clients interviewed echoed this woman's sentiment that the team had treated them with respect. Non-client respondents also highlighted the team's respect for clients and their belief in client competency as accounting for its positive impact on clients.

Program Influence on the Client Community

Changes in the client community as a whole, including increased acts of mutual aid, greater cohesiveness, and diminished distrust of mental health services, were found to be directly related to program influence. These changes can be interpreted as a shift in group norms. Prior to the inception of the program, the community was one in which bizarre behavior was accepted, mental health services were stigmatized, and interaction among the women was characterized by hostility and distrust. After the inception of the program, a sense of commonality, belonging, and caring began to emerge among the women. As one client described the change in the community:

> The program helped create a different atmosphere here. Now the women care about each other, they think in terms of each other instead of just themselves...The tenants harmonize more. They have more respect for each other because the groups have taught them to listen to each other, to hear each other's points of view...When you get a chance to talk to people in the groups you find out you have something in common...The program made a big difference in helping us get to know each other...we became more united.

A sense of empowerment was born, out of the growing unity which developed among the clients. Empowerment was supported by the staff's view of clients as competent adults. This was embodied by the service relationship in which clients were viewed as active partners, rather than passive recipients of services. It was also embodied by the clients involvement, albeit somewhat limited, in program planning. Active involvement in the program led to more more active participation in the day to day life of the hotel beyond the purview of the program. Clients began making demands as tenants and eventually organized a tenants' association. Clients began to take control over their immediate environment. The sense of powerlessness that had once prevailed among these women gave way to a new found sense of efficacy.

Implications for Social Work Practice

This case study has relevance beyond the confines of one particular program. The experience of this small group of social workers and clients has important implications for work practice with this challenging client population.

The CSS program sought to promote client empowerment, as have other programs for homeless mentally ill clients described in the literature (Lee, 1986; Breton, 1988; Martin and Neyowith, 1988). Empowerment, in this context, refers to the goal of helping clients from powerless groups become effective and creative participants in their environments (Rose and Black, pp. 33-34) who "believe in their ability to shape events in their lives" (Sue, 1987, p.87).

The experience of homelessness and mental illness is actively disempowering. Life on the streets, in shelters, and in psychiatric institutions fosters a pervasive sense of helplessness in the face of powerful external forces. Homeless mentally ill individuals learn that there is little predictability in the environment. They lose their

belief in their ability to shape events in their lives.

An empowerment oriented framework for practice seeks to repair some of the damaging effects of homelessness and mental illness. It builds on client strengths and maximizes opportunities for effective participation in the environment. It reduces power differentials between worker and client through a partnership approach in which the worker provides tools and the client makes decisions. Generalist practice skills, such as engagement, contracting, and assessment, can be readily adapted to this practice framework.

Engagement skills are critical in work with this disaffiliated population. Homeless mentally ill people are often slow to trust and must be met on their own terms. Engagement often has to proceed slowly, with the client setting the pace in the service relationship. For engagement to be effective, mutuality must be present from the outset. Reluctance on the part of clients to accept services is most readily overcome when services are voluntarily offered, rather than imposed. The opportunity to accept or reject services provides clients with some control over their lives, control that has been too often lacking in their experiences with professionals. In the study of the CSS program, clients reported that they felt comfortable using program services only after they realized that their participation in the program was completely voluntary.

For engagement to be successful, it is important that services match the perceived needs of clients. These needs are often the most basic ones such as sustenance and protection against the elements. Engagement strategies might include providing food, clothing, shelter, and assistance with entitlements. While counseling and psychiatric intervention may be needed, few clients initially seek these services. Once the client has been engaged through the voluntary provision of services that match the client's perceived needs, other forms of intervention can be negotiated (Cohen, 1989).

Contracting with homeless mentally ill clients requires considerable patience and creativity. Contracting, which has been defined as "the process by which worker and client reach a shared definition of the problem and an explicit mutual agreement about their goals, tasks, respective roles and terms of work" (Germain and Gitterman, 1980, p. 53) is inherently client-centered. Although it has been suggested that contracting is often not possible with severely impaired clients (Shulman, 1984), the goal of empowerment

demands that practitioners find ways to adapt the contracting process to all clients. This often means beginning with partial contracts, such as an agreement that the client will accept a cup of coffee from the worker each day or an agreement that the client and worker will go for a walk around the block once a week and "chat." Once partial contracts are successfully negotiated they can be more fully elaborated to include specific service goals.

Contracting can be used as a means to move the work forward while ensuring that decisions are made through consensus rather than coercion. It implies a partnership between the worker and client which serves to reduce the power discrepancy that is inherent in the helping relationship (Germain and Gitterman, 1980). To omit this phase of the helping process on the basis of client impairment actively disempowers clients. Contracting provides opportunities for empowerment by maximizing client control over the objectives and terms of work (Cohen, in press).

Assessment with homeless mentally ill clients, as with any client group, requires skill in examining relevant information regarding the biological, psychological, social and environmental dimensions of the client situation. There are, however, particular aspects of clients' social histories that social workers working with this population must be sensitive to: histories of institutionalization, medical histories, and histories of homelessness.

While psychiatric histories are generally included in psychosocial assessments of clients who have been diagnosed as mentally ill, an additional focus suggested here is an assessment of the client's experience in the mental health system. The fears that many homeless mentally ill clients have of hospitals, psychiatrists, and medication are best understood and responded to with knowledge of the client's particular experiences in psychiatric settings (Cohen, in press).

Information regarding clients' medical histories is extremely important in view of the high incidence of a wide range of medical problems in the homeless population related to the poor nutrition, high stress, and lack of physical safety associated with homelessness (Brickner, et al, 1985). Medical care is often inaccessible to homeless people, many of whom are also reluctant to seek treatment.

Knowledge of clients' past experiences with homelessness is of great importance in assessment and service planning. If clients are to be prepared for and connected with housing resources, an assessment of which living situations have

worked for them in the past, as well as which ones have been stressful, is necessary. It is also important for the social worker and the client to identify any cyclical patterns in the client's homelessness history, in order to minimize the likelihood of their repetition.

Assessment promotes empowerment when it is a mutual endeavor in which client strengths are emphasized. In this process, the social worker and client explore together the realities of the client's present and past circumstances in order to uncover strengths, identify sources of support, and determine service needs.

Group discussions and activities can be used to promote collective client empowerment. Groups have been used successfully in many programs for homeless mentally ill clients to create and strengthen client communities characterized by mutual aid and reciprocal advocacy (Lee, 1986; Breton, 1988; Glasser and Suroviak; Martin and Neyowith, 1988). As the women in the CSS program discovered, mutual aid groups provide opportunities to explore common experiences and work together on shared goals. Empowerment occurs when clients learn from each other, pool information and skills, and advocate on each other's behalf.

The active involvement of clients in service and program planning provides clients with some of the tools necessary for regaining control over their lives. Inviting clients, who have historically been viewed as "unable" and "not competent," to play a role in designing program services communicates a powerful message about client competency while providing concrete opportunities for the development of interpersonal and decision making skills. This invitation must be a voluntary one, not every client will want to avail herself of this opportunity. Even clients who choose not to be involved in program planning may feel empowered, however, by having this choice to make.

The experiences of clients and social workers in the CSS program suggests that this approach to practice is both feasible and effective. Further research is needed to elaborate and refine this practice model and to investigate its potential application to other vulnerable and disenfranchised client populations.

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